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IMAGES IN CARDIOLOGY

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Percutaneous removal of embolised vegetation from left main coronary artery

A 55 year old man presented with acute central chest pain two weeks after undergoing redo aortic valve replacement for *Streptococcus mitis* prosthetic endocarditis. His past history included cadaveric renal transplantation for adult polycystic kidney disease. He was receiving intravenous antibiotics at presentation and was afebrile with a normal white count. His ECG is shown in the upper panel.

Primary percutaneous coronary intervention (PCI) was planned. Diagnostic angiography via the right radial demonstrated a filling defect in the left main stem not present at preoperative angiography (panel A).

Emergency bypass surgery was considered to be of prohibitively high risk. In view of the likely haemodynamic instability a percutaneous left ventricular assist device (PVAD) (TandemHeart) was inserted (panel B, arrow). The 21 French venous cannula which was passed across the atrial septum (after predilatation of a patent foramen ovale) and the 17 French femoral artery cannula allowed a flow of approximately 3 l/min. Following this the vegetation was aspirated using an Angiojet device. The filling defect was successfully removed but the left main ostium appeared compromised (panel C). A 3.5 × 20 mm Taxus stent was deployed in the left main ostium, which was then post-dilated with a 4 × 20 Quantum non-compliant balloon. An excellent angiographic result (panel D) was obtained with no evidence of major distal embolism. The PVAD was removed after 48 hours. Over the next week, the patient's ejection fraction improved from 25% to 45% and he was discharged home on day 10 after intervention.

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